STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00117917. Complaint IN00117917-Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F314. Survey dates: October 22, 23, 24 2012 Facility number 000149 Provider number 155245 AIM number 100266840 Survey team: Chuck Stevenson, RN Census bed type: SNF/NF: 55 Total: 55 Census payor type: Medicare: 11 Medicaid: 36 Other: 8 Total: 55 Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on October 29, 2012 by Bev Faulkner, RN	F0000	Submission of this Plan of Correction shall not constitute or be construed as an admisson by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview, and record review, the facility failed to develop a health care plan for prevention of pressure ulcers for a resident who was at risk for pressure ulcers based on diagnoses and mobility until after the resident had developed pressure sores for 1 of 3 residents reviewed for care plans in a sample of 5. (Resident B). Findings include: 1. The record of Resident B was reviewed on 10/22/12 at 1:00 p.m.	F0279	It is the intent of this facility that all residents have a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. Describe what facility did to correct the alleged deficient practice for each resident cited in the deficiency. Resident B no longer resides at the facility. Decribe how the facility reviewed all clients in the facility that could be affected by the same alleged deficient	11/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Diagnoses included, but were not limited to, diabetes mellitus, hypertension, anemia, a history of colon cancer, a history of compression fracture of the spine, a history of hip fracture with open reduction and internal fixation, agitation, gastro esophageal reflux disease, and respiratory distress. An initial Minimum Data Set assessment, dated 9/29/12, indicated Resident B was cognitively impaired, had trouble concentrating, had physical and verbal behaviors directed toward others, did not ambulate, was totally dependent on staff for bed mobility, was frequently incontinent of bowel and bladder, and required extensive staff assistance for activities of daily living. An "Admission Nursing Assessment," dated 9/10/12, the date of Resident B's admission to the facility, indicated surgical incisions to the right hip. No pressure sores or other skin concerns were documented on admission. An Interim Admission Care Plan, dated 9/10/12, contained no care plan for risk for skin breakdown or pressure ulcers. Nurse's notes for Resident B on 9/30/12 at 10:30 p.m., indicated "An area of about 3.4 x (times) 3 cm (centimeters) was		practice, and state, what actions the facility took to correct the alleged deficient practice for any resident the facility identified as being affected. 1. Skin assessments were completed on all residents to assess for any areas of skin break down. 2. A Braden Scale was completed for all residents to assess their risk for skin breakdown or pressure ulcers. 3. Care Plans were reviewed and updated as appropriate for all residents with current skin issues and those at high risk for potential breakdown. 4. Treatment orders for residents with current skin breakdown were reviewed for efficacy and changed as appropriate. 5. Progress notes from Wound Care Consultants were reviewed and recommedations implemented as appropriate. 6. C.N.A. Assignment Sheets were updated as appropriate. 7. Staff were in-serviced on cause and prevention of skin breakdown presented by Wouund Care Consultants staff and the facility's D.O.N./designee. 8. Licensed nursing staff were in-serviced on proper measuring, staging and treatments of wounds by Wound Care Consultants staff and facility D.O.N./designee. Describe the steps or systemic changes the facility has made to ensure that the alleged deficient practice does not recur. 1. All new admission and re-admission charts will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING 00	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	noted on his lower buttock..." Resident B's nurse's notes contained no other reference to skin condition, including assessment and/or treatment. A "Skin Assessment Verification" form, dated 9/30/12, indicated Resident B had a Stage ll pressure sore to her sacral area measuring 3.4 by 3.0 centimeters. Treatment was indicated to be "Calmo q shift" (calmoseptine ointment every shift). No other treatment or intervention was noted. A care plan, dated 10/02/12, indicated "Resident is at risk for developing a pressure ulcer..." The record contained no care plan for the development of a pressure sore as identified in the Skin Assessment Verification form dated 9/30/12. A "Wound Progress Note," dated 10/03/12, completed by Advanced Practice Nurse/Wound Care Specialist indicated: "Wound Location: Sacrum. Measurements: 8.0 by 9.0 by 0.1 centimeters. Etiology (Type): Pressure		reviewed during the facility Morning Meeting (Monday-Friday) by the D.O.N./designee for proper completion of assessments and care plans. 2. C.N.A. Assignment Sheets will be updated on an on-going basis as needed/appropriate. 4. Results of chart audits will be presented by D.O.N./designee to QA Committee during monthly QA Meetings for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Stage: Unstageable/DTI (Deep Tissue Injury) Type of Tissue: Red...Fragile Diagnosis/Plan: Unstageable-DTI-sacrum...DC briefs in bed. Upgrade mattress.." During an interview with the Director of Nursing (D.O.N.) on 10/24/12 at 2:30 p.m., she indicated that care staff were encouraged to not use briefs on residents in bed, but that there was no documentation of specific instructions to not use briefs for Resident B while in bed, and no documentation of whether this had been done. She also indicated that Resident B's mattress had not been upgraded from the facility's standard foam mattress. Resident B's record contained no reference to a turning or repositioning schedule. During an interview on 10/23/12 at 3:45 p.m., the D.O.N. indicated the facility did not document the need for turning schedules for residents at risk for pressure sores, either as a physician's order or as a nursing measure. She indicated there was no place in the resident's record designated to document turning or repositioning as performed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She indicated CNA assignment sheets noted "Turn Q 2 hr" (Turn every 2 hours) and it was "assumed" that staff would know to turn residents who were at risk for pressure sores. 2. A facility policy, dated 8/14/2008, titled "Comprehensive Care Plans" received from the D.O.N. on 10/23/12 at 8:45 a.m., indicated: "Policy: The facility shall develop a comprehensive care plan for each resident...All staff personnel who provide care...shall be knowledgeable of, and have access to, the resident's plan of care." This federal tag relates to Complaint IN00117917. 3.1-35(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to provide necessary services and treatment to prevent the development of pressure sores (stage ll to the left buttock, stage lll to the right buttock) for 1 resident who was admitted without pressure sores of 3 residents reviewed for pressure sores in a sample of 5. (Resident B) Findings include: 1. The record of Resident B was reviewed on 10/22/12 at 1:00 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, anemia, a history of colon cancer, a history of compression fracture of the spine, a history of hip fracture with open reduction and internal fixation, agitation, gastro esophageal reflux disease, and respiratory distress.	F0314	It is the intent of this facility to, based on the comprehensive assessment of a resident, ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Describe what facility did to correct the alleged deficient practice for each resident cited in the deficiency. 1. Resident B no longer resides at the facility. Decribe how the facility reviewed all clients in the facility that could be affected by the same alleged deficient practice, and state, what actions the facility took to correct the alleged deficient practice for any resident the facility identified as being affected. 1. Skin assessments were completed on	11/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An initial Minimum Data Set assessment, dated 9/29/12, indicated Resident B was cognitively impaired, had trouble concentrating, had physical and verbal behaviors directed toward others, did not ambulate, was totally dependent on staff for bed mobility, was frequently incontinent of bowel and bladder, and required extensive staff assistance for activities of daily living. An "Admission Nursing Assessment," dated 9/10/12 the date of Resident B's admission to the facility, indicated surgical incisions to the right hip. No pressure sores or other skin concerns were documented on admission. A "Bowel and Bladder Assessment," dated 9/10/12, indicated "Condition of Skin: No redness." Resident B's admission orders and recapitulation of orders for October 2012 indicated "Pressure Relieving Mattress." Per interview wit the Director of Nursing (D.O.N.) on 10/23/12 at 11:45 a.m., this is the standard foam mattress used for all residents in the facility. Resident B was sent to the hospital on 9/11/12 with symptoms of respiratory distress, and returned to the facility on		all residents to assess for any areas of skin break down. 2. A Braden Scale was completed for all residents to assess their risk for skin breakdown or pressure ulcers. 3. Care Plans were reviewed and updated as appropriate for all residents with current skin issues and those at high risk for potential breakdown. 4. Treatment orders for residents with current skin breakdown were reviewed for efficacy and changed as appropriate. 5. Progress notes from Wound Care Consultants were reviewed and recommedations implemented as appropriate. 6. C.N.A. Assignment Sheets were updated as appropriate. 7. Staff were in-serviced on cause and prevention of skin breakdown presented by Wouund Care Consultants staff and the facility's D.O.N./designee. 8. Licensed nursing staff were in-serviced on proper measuring, staging and treatments of wounds by Wound Care Consultants staff and facility D.O.N./designee. Describe the steps or systemic changes the facility has made to ensure that the alleged deficient practice does not recur. 1. All new admission and re-admission charts will be reviewed during the facility Morning Meeting (Monday-Friday) by the D.O.N./designee for proper completion of assessments and care plans. 2. C.N.A. Assignment Sheets will be updated on an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9/22/12. A hospital "Transfer/Referral Form," dated 9/22/12, indicated "Skin: redness around coccyx." An "Admission Nursing Assessment," dated 9/22/12 the date of Resident B's readmission to the facility, indicated "Ext (extensive) Discoloration Buttock Excoriation." A physician's order, dated 9/22/12, indicated "Buttock Excoriated use calmoseptine to buttock q (every) shift until healed." The record indicated no other treatment or intervention for risk for pressure sores at that time. Nurse's notes for Resident B on 9/30/12 at 10:30 p.m., indicated "An area of about 3.4 x (times) 3 cm (centimeters) was noted on his lower buttock..." Resident B's nurse's notes contain no other reference to skin condition, including assessment and/or treatment. A "Skin Assessment Verification" form, dated 9/30/12, indicated Resident B had a Stage ll pressure sore to her sacral area measuring 3.4 by 3.0 centimeters. Treatment was indicated to be "Calmo q shift" (calmoseptine ointment every shift). No other treatment or intervention was		on-going basis as needed/appropriate. 4. Results of chart audits will be presented by D.O.N./designee to QA Committee during monthly QA Meetings for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	noted. A "Wound Progress Note," dated 10/03/12, completed by Advanced Practice Nurse/Wound Care Specialist indicated: "Wound Location: Sacrum. Measurements: 8.0 by 9.0 by 0.1 centimeters. Etiology (Type): Pressure Stage: Unstageable/DTI (Deep Tissue Injury) Type of Tissue: Red...Fragile Diagnosis/Plan: Unstageable-DTI-sacrum...DC briefs in bed. Upgrade mattress.." During an interview with the Director of Nursing (D.O.N.) on 10/24/12 at 2:30 p.m., she indicated that care staff were encouraged to not use briefs on residents in bed, but that there was no documentation of specific instructions to not use briefs for Resident B while in bed, and no documentation of whether this had been done. She also indicated that Resident B's mattress had not been upgraded from the facility's standard foam			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mattress. Resident B was sent back to the emergency room on 10/07/12 secondary to diarrhea and coffee grounds emesis. Hospital records, which include Forensic Nursing evaluation with documentation and photos, indicated that on presentation to the Emergency Room, Resident B had a Stage lll pressure sore on the right buttock measuring 2.5 by 2.5 centimeters with surrounding redness of 7 by 5 centimeters. The left buttock was noted to have "3 small" Stage ll pressure sores with surrounding redness of 5 by 10 centimeters. The resident was admitted to the hospital and wound care treatment was begun. Resident B returned to the facility on 10/22/12. A "Skin Assessment Verification" form on that date indicated the presence of a Stage l pressure sore to the coccyx measuring 2.5 by 2.0 centimeters and a Stage ll pressure sore to the left buttock measuring 1.5 by 0.7 centimeters. Resident B's pressure sores were observed on 10/23/12 at 9:15 a.m. The wounds were noted to be consistent with the documentation on the 10/22/12 Skin Assessment Verification. The resident remained on the facility's standard foam			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mattress. Records indicated a low air loss mattress was ordered on that date. Resident B's record contained no reference to a turning or repositioning schedule. During an interview on 10/23/12 at 3:45 p.m., the D.O.N. indicated that the facility did not document the need for turning schedules for residents at risk for pressure sores, either as a physician's order or as a nursing measure. She indicated there was no place in the resident's record designated to document turning or repositioning as performed. She indicated CNA assignment sheets noted "Turn Q 2 hr" (Turn every 2 hours) and it was "assumed" that staff would know to turn residents who were at risk for pressure sores. 2. A facility policy dated 10/24/2011 received from the D.O.N. on 10/23/12 at 8:45 a.m., indicated: "Purpose: To provide identification of pressure ulcer risk factors and interventions for the risk factors...Once a pressure ulcer develops, it can be extremely difficult to heal. The facility should have a system to assure timely and appropriate evaluation... Interventions and Preventive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Measures...Place resident on a minimum of a q (every) hour turning and repositioning program." This federal tag relates to Complaint IN00117917. 3.1-40(a)(1)			